Filing at a Glance

Company:	Federated Mutual Insurance Company
Product Name:	Group Health
State:	Arkansas
TOI:	H16G Group Health - Major Medical
Sub-TOI:	H16G.001A Any Size Group - PPO
Filing Type:	Form
Date Submitted:	01/21/2013
SERFF Tr Num:	FEMC-128859512
SERFF Status:	Closed-Approved-Closed
State Tr Num:	
State Status:	Approved-Closed
Co Tr Num:	
Implementation Date Requested:	01/01/2014
Author(s):	Kayla Paape
Reviewer(s):	Rosalind Minor (primary)
Disposition Date:	01/30/2013
Disposition Status:	Approved-Closed
Implementation Date:	

State Filing Description:

State: *Arkansas* **Filing Company:** *Federated Mutual Insurance Company*
TOI/Sub-TOI: *H16G Group Health - Major Medical/H16G.001A Any Size Group - PPO*
Product Name: *Group Health*
Project Name/Number: *Section 2-Enrollment & Effective Date/GH 03 02 (01-14 ed.)*

General Information

Project Name: Section 2-Enrollment & Effective Date
Project Number: GH 03 02 (01-14 ed.)
Requested Filing Mode: Review & Approval
Explanation for Combination/Other:
Submission Type: New Submission
Group Market Type: Employer
Filing Status Changed: 01/30/2013
State Status Changed: 01/30/2013
Created By: Kayla Paape
Corresponding Filing Tracking Number:

Status of Filing in Domicile: Not Filed
Date Approved in Domicile:
Domicile Status Comments:
Market Type: Group
Group Market Size: Small and Large
Overall Rate Impact:

Deemer Date:
Submitted By: Kayla Paape

PPACA: Non-Grandfathered Immed Mkt Reforms, Grandfathered Immed Mkt Reforms

PPACA Notes: null

Include Exchange Intentions: No

Filing Description:

Federated Mutual Insurance Company is submitting a revised Enrollment & Effective Date section of our policy and certificate form, GH 03 02 (01-14 ed.). This will replace form, GH 03 02 (01-12 ed.), which was previously approved on 09/06/2011 under SERFF tracking No. FEMC-127384610/State tracking No. 49633.

The form has been revised to include an open enrollment period and to remove the pre-existing condition limitations (required by ACA). A redline comparison is attached to the Supporting Documentation tab.

This section will be used in conjunction with policy form GH 03 10 (01-12 ed.) and certificate form GH 03 11 (01-12 ed.) both approved by your department on 09/06/2011 under SERFF tracking No. FEMC-127384610/State tracking No. 49633.

Company and Contact

Filing Contact Information

Kayla Paape, Compliance Analyst
121 East Park Square
Owatonna, MN 55060

klpaape@fedins.com
800-533-0472 [Phone] 455-8052 [Ext]
507-444-4840 [FAX]

Filing Company Information

Federated Mutual Insurance Company
121 East Park Square
PO Box 328
Owatonna, MN 55060
(800) 533-0472 ext. [Phone]

CoCode: 13935
Group Code: 7
Group Name:
FEIN Number: 41-0417460

State of Domicile: Minnesota
Company Type:
State ID Number:

Filing Fees

SERFF Tracking #: *FEMC-128859512* ***State Tracking #:*** ***Company Tracking #:***

State: *Arkansas* ***Filing Company:*** *Federated Mutual Insurance Company*
TOI/Sub-TOI: *H16G Group Health - Major Medical/H16G.001A Any Size Group - PPO*
Product Name: *Group Health*
Project Name/Number: *Section 2-Enrollment & Effective Date/GH 03 02 (01-14 ed.)*

Fee Required?	Yes
Fee Amount:	$125.00
Retaliatory?	Yes
Fee Explanation:	MN filing fee is $125 per policy
Per Company:	No

Company	Amount	Date Processed	Transaction #
Federated Mutual Insurance Company	$125.00	01/21/2013	66727780

SERFF Tracking #:	*FEMC-128859512*	***State Tracking #:***		***Company Tracking #:***	

State:	*Arkansas*	***Filing Company:***	*Federated Mutual Insurance Company*
TOI/Sub-TOI:	*H16G Group Health - Major Medical/H16G.001A Any Size Group - PPO*		
Product Name:	*Group Health*		
Project Name/Number:	*Section 2-Enrollment & Effective Date/GH 03 02 (01-14 ed.)*		

Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Rosalind Minor	01/30/2013	01/30/2013

SERFF Tracking #:	*FEMC-128859512*	***State Tracking #:***	***Company Tracking #:***

State:	*Arkansas*	***Filing Company:***	*Federated Mutual Insurance Company*
TOI/Sub-TOI:	*H16G Group Health - Major Medical/H16G.001A Any Size Group - PPO*		
Product Name:	*Group Health*		
Project Name/Number:	*Section 2-Enrollment & Effective Date/GH 03 02 (01-14 ed.)*		

Disposition

Disposition Date: 01/30/2013
Implementation Date:
Status: Approved-Closed

HHS Status: HHS Approved
State Review: Reviewed-No Actuary

Comment:

Rate data does NOT apply to filing.

Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification	Approved-Closed	Yes
Supporting Document	Application	Approved-Closed	Yes
Supporting Document	PPACA Uniform Compliance Summary	Approved-Closed	Yes
Supporting Document	Redline Section 2	Approved-Closed	Yes
Form	Sect 2-Enrollment & Effective Date	Approved-Closed	Yes

SERFF Tracking #:	*FEMC-128859512*	***State Tracking #:***		***Company Tracking #:***	

State:	*Arkansas*	***Filing Company:***	*Federated Mutual Insurance Company*
TOI/Sub-TOI:	*H16G Group Health - Major Medical/H16G.001A Any Size Group - PPO*		
Product Name:	*Group Health*		
Project Name/Number:	*Section 2-Enrollment & Effective Date/GH 03 02 (01-14 ed.)*		

Form Schedule

Lead Form Number: GH 03 02 (01-14 ed.)

Item No.	Schedule Item Status	Form Name	Form Number	Form Type	Form Action	Action Specific Data		Readability Score	Attachments
1	Approved-Closed 01/30/2013	Sect 2-Enrollment & Effective Date	GH 03 02 (01-14 ed.)	POL	Revised	Previous Filing Number:	FEMC-127384610		GH 03 02 (01-14 ed.).pdf
						Replaced Form Number:	GH 03 02 (01-12 ed.)		

Form Type Legend:

ADV	Advertising	**AEF**	Application/Enrollment Form
CER	Certificate	**CERA**	Certificate Amendment, Insert Page, Endorsement or Rider
DDP	Data/Declaration Pages	**FND**	Funding Agreement (Annuity, Individual and Group)
MTX	Matrix	**NOC**	Notice of Coverage
OTH	Other	**OUT**	Outline of Coverage
PJK	Policy Jacket	**POL**	Policy/Contract/Fraternal Certificate
POLA	Policy/Contract/Fraternal Certificate: Amendment, Insert Page, Endorsement or Rider	**SCH**	Schedule Pages

SECTION II - ENROLLMENT & EFFECTIVE DATE

Words and phrases appearing in **bold type** have special meaning as set forth in Section VIII - Definitions.

1. **EMPLOYER** ENROLLMENT AND EFFECTIVE DATE

   a. An **employer** shall apply to become a **policyholder**. The **employer** will become a **policyholder** on the first day of the **month** coinciding with or following the date such **employer** applies subject to:

      i. approval by **us**; and

      ii. meeting the participation requirements shown below; and

      iii. meeting the contribution requirements shown below.

   b. Once an **employer** becomes a **policyholder** they can make changes to the policy chosen either:

      i. prior to the anniversary of their original effective date to be effective on the anniversary of their original effective date; or

      ii. prior to 12:01 am Central Standard Time on December 15 any **calendar year** to be effective on the first day of January.

2. PARTICIPATION REQUIREMENTS

   a. When the **employer** pays the entire premium:

      If the **employer** is paying the entire premium for each **covered employee**, 100% of the eligible **employees** not covered under a separate unrelated employer's plan must be enrolled for coverage at all times.

      If the **employer** is paying the entire premium for each covered **dependent**, 100% of the eligible **dependents** not covered under a separate unrelated employer's plan must be enrolled for coverage at all times.

   b. When **covered employees** contribute to the premium payment:

      If **covered employees** contribute to the premium payment for their own coverage, a minimum of 85% of all eligible **employees** not covered under a separate unrelated employer's plan must be enrolled at all times.

      If **covered employees** contribute to the premium payment for their **dependents**' coverage, a minimum of 85% of all eligible **dependents** not covered under a separate unrelated employer's plan must be enrolled at all times.

      In addition, a minimum of two (2) eligible **employees** must always be insured under each **employer's** plan in order for coverage to be issued or continued.

3. CONTRIBUTION REQUIREMENTS

   When an **employer** does not pay the full premium for **covered employees** and **dependents**, the **employer** must:

   a. pay a minimum of 70% of the premium for **covered employees**; or

   b. pay a minimum of 35% of the total premium for **covered employees** and **dependents**.

4. **EMPLOYEE** ELIGIBILITY

   a. An **employee** is eligible to enroll for coverage under the **policy** if he is **actively at work** or absent from work due to a **health status related factor** and:

      i. has completed the **waiting period** shown in the **employer's** application for coverage; or

      ii. was covered under the **employer's** prior plan on the day before the effective date of the **employer's** coverage with **us**.

   b. An **employee** is only eligible for **dependent** coverage if he elects **employee** coverage.

   c. Once enrolled, an **employee** is eligible for coverage under the **policy** only if he is **actively at work**.

5. **DEPENDENT** ELIGIBILITY

   a. **Dependents** are eligible to enroll for coverage under the **policy** if:

      i. they meet the definition of a **dependent** in Section VIII - Definitions; and

      ii. the **employee** is covered under the **policy**; and

      iii. the additional premium for **dependent** coverage is paid.

   b. Once enrolled, a **dependent** is eligible for coverage under the **policy** only if he meets the definition of a **dependent** in Section VIII - Definitions.

6. OPEN ENROLLMENT PERIOD

   The “open enrollment period” will be from 12:01 am Central Standard Time on October 1 through 12:01 am Central Standard Time on December 15 each calendar year. Coverage for an employee or dependent that enrolls during the “open enrollment period” will be effective on the first day of January following their enrollment.

7. **EMPLOYEE** EFFECTIVE DATE

   Each eligible **employee** may elect coverage by completing and signing an application. The effective date of his coverage depends upon the date on which the **employee** elects the coverage.

   a. If elected on or before the date he becomes eligible, his coverage will be effective on the first day of the **month** after he becomes eligible.

   b. If elected within 31 days after he becomes eligible, his coverage will be effective on the first day of the **month** after election.

   c. If not elected within 31 days after he becomes eligible, an **employee** can only enroll for coverage during the “open enrollment period” established by **us** or according to the special enrollment provisions in item 11 below. If an **employee** enrolls during an “open enrollment period” his coverage will be effective on the first day of January following his enrollment.

8. **DEPENDENT** EFFECTIVE DATE (other than newborn or adopted children)

   Each **covered employee** may elect **dependent** coverage by completing and signing an application. The effective date of coverage for each **dependent**, except newborn or adopted children, depends upon the date on which the **employee** elects coverage for that **dependent**. If a **dependent** is no longer covered because his eligibility ended, he must re-enroll for coverage if he becomes eligible again. Coverage is not automatically reinstated for **dependents** that were previously covered.

   Coverage for a newborn or adopted child is effective as outlined in subparts 9 & 10 below.

   a. If elected on or before the date the **employee** becomes eligible, the coverage for each **dependent** will be effective on the first day of the **month** after the **employee** becomes eligible.

   b. If elected within 31 days after the **employee** becomes eligible, the coverage for each **dependent** will be effective on the first day of the **month** after election.

   c. If not elected within 31 days after the **employee** becomes eligible, each **dependent** can only enroll for coverage during the “open enrollment period” established by **us** or according to the special enrollment provisions in item 11 below. If a **dependent** enrolls during an “open enrollment period” his coverage will be effective on the first day of January following his enrollment.

   d. If the **employee** acquires an additional **dependent** the effective date of coverage will be according to the special enrollment provisions in item 11 below.

9. NEWBORN'S EFFECTIVE DATE

   The effective date of coverage for a newborn **dependent** child who is born while an **employee** is a **covered employee** will be as follows:

   a. Coverage will be in effect from the moment of birth if within 90 days of the birth of a child who would qualify as a **dependent** of the **covered employee**:

      i. notifies **us** of the birth of a child; and

      ii. **we** receive payment of any required premium for coverage of the child as a **dependent**

b. If the **covered employee** does not provide notice and pay any required premium within 90 days of the birth of a child who would qualify as a **dependent**, coverage for that child can only be added during the "open enrollment period" as set forth above or according to the special enrollment provisions in item 11 below. If a newborn **dependent** enrolls during an "open enrollment period" his coverage will be effective on the first day of January following his enrollment.

10. ADOPTED CHILD EFFECTIVE DATE

The effective date for a **dependent** child who is adopted by an **employee** while he is a **covered employee** will be as follows:

a. Coverage will be in effect from the date of the "placement for adoption" if within 60 days of the "placement for adoption" of a child who would qualify as a **dependent** the **covered employee**:

i. notifies **us** of the "placement for adoption" of the child; and

ii. **we** receive payment of any required premium for coverage of the child as a **dependent.**

b. If the **covered employee** does not provide notice and pay any required premium within 60 days of the "placement for adoption" of a child who would qualify as a **dependent**, coverage for that child can only be added during the "open enrollment period" as set forth above or according to the special enrollment provisions in item 11 below. If an adopted **dependent** enrolls during an "open enrollment period" his coverage will be effective on the first day of January following his enrollment.

The term "Placement for Adoption" means the earlier of:

i. the date of placement of the child with the **covered employee** for purposes of adoption;

ii. the date of entry of an order granting the **covered employee** custody of the child for purposes of adoption; or

iii. the effective date of the adoption by the **covered employee**.

The child's placement with the **covered employee** terminates if prior to legal adoption the child is removed from the placement.

11. SPECIAL ENROLLMENT PROVISIONS

a. For Individuals Losing Other Coverage

An **employee** and any eligible **dependents** who are otherwise eligible under the **policy**; and failed to enroll when first eligible may enroll for coverage outside the "open enrollment period", but only if each of the following conditions are met:

i. the **employee** and/or any eligible **dependents** were covered under a group health plan or had other health coverage (includes benefits consisting of medical care under any hospital or medical services policy or certificate, or HMO policy) at the time coverage under the **policy** was first offered; and

ii. the **employee** stated in writing that coverage under such group health plan or health insurance coverage was the reason for declining enrollment; but only if **we** required such a statement and provided the **employee** with notice of such requirement (and the consequences of such requirement) at such time; and

iii. if such coverage:

(1) was under a **COBRA** continuation provision and the coverage under such provision was exhausted; or

(2) was not under a **COBRA** continuation provision and the coverage was terminated as a result of either:

(a) legal separation; divorce; death; termination of employment; or reduction in the number of hours of employment; or

(b) the current or former employer contributions toward such coverage terminating; and

iv. the **employee** requests enrollment under the **policy** for the **employee** and/or any eligible **dependents** not later than 30 days after the date such other coverage ended. The coverage will become effective on the first day of the **month** following **our** receipt of the enrollment request; or on an earlier date, as agreed to by **us**.

b. For Individuals Otherwise Eligible

In addition to the eligibility provisions contained in the **policy**, the following also applies:

i. If the **employee** is covered under the **policy** (or has met any **waiting period** and is eligible to enroll under the **policy**, but did not enroll during a previous enrollment period); and a person becomes an eligible **dependent** through marriage, birth, adoption or placement for adoption; **we** will provide:

(1) a special enrollment period described below during which such **dependent** may be enrolled under the **policy**;

(2) in the case of the birth or adoption of a child, a special enrollment period for the **employee's spouse** to enroll as a **dependent** if otherwise eligible for coverage.

The **employee** must be eligible for coverage and enrolled under the **policy** for coverage to be effective for the **employee's dependent**. If the **employee** is not enrolled, the **employee** may enroll at the same time as the **dependent** during this special enrollment period.

ii. The special enrollment period will be a period of 30 days, and begins on the later of:

(1) the date **dependent** coverage is made available under the **policy**; or

(2) the date of the marriage, birth, adoption or placement for adoption.

iii. If the **employee** requests enrollment under the **policy** for the **employee** and/or any eligible **dependents** during the 30 days of such special enrollment period, the coverage will be effective:

(1) in the case of marriage, on the first day of the **month** following **our** receipt of the enrollment request; or on an earlier date as agreed to by **us**;

(2) in the case of a **dependent's** birth, on the date of such birth; or

(3) in the case of a **dependent's** adoption or placement for adoption, the date of such adoption or placement for adoption.

SERFF Tracking #:	*FEMC-128859512*	***State Tracking #:***	***Company Tracking #:***

State:	*Arkansas*	***Filing Company:***	*Federated Mutual Insurance Company*
TOI/Sub-TOI:	*H16G Group Health - Major Medical/H16G.001A Any Size Group - PPO*		
Product Name:	*Group Health*		
Project Name/Number:	*Section 2-Enrollment & Effective Date/GH 03 02 (01-14 ed.)*		

Supporting Document Schedules

		Item Status:	**Status Date:**
Satisfied - Item:	Flesch Certification	Approved-Closed	01/30/2013
Comments:			
Attachment(s):			
AR Certification of Compliance.pdf Readability Certification.pdf			

		Item Status:	**Status Date:**
Satisfied - Item:	Application	Approved-Closed	01/30/2013
Comments:	The Employer Application, 1400 Ed. 02-12, was approved on 11/05/2012 under SERFF Tracking No. FEMC-128746933. The Employee Application, 4420 Ed. 01-13, was filed for review and approval on 01/21/2013 under SERFF Tracking No. FEMC-128859706.		
Attachment(s):			
1400 Ed. 02-12.pdf 4420 (01-13).pdf			

		Item Status:	**Status Date:**
Satisfied - Item:	PPACA Uniform Compliance Summary	Approved-Closed	01/30/2013
Comments:			
Attachment(s):			
PPACA Uniform Compliance Summary.pdf			

		Item Status:	**Status Date:**
Satisfied - Item:	Redline Section 2	Approved-Closed	01/30/2013
Comments:			
Attachment(s):			
GH 03 02 (01-14 ed.)redline.pdf			

121 East Park Square
P.O. Box 328 • Owatonna, MN 55060
Phone: (507) 455-5200 • 800-533-0472

FEDERATED MUTUAL INSURANCE COMPANY

Owatonna, Minnesota

January 21, 2013

CERTIFICATE OF COMPLIANCE

Arkansas

I hereby certify that Federated Mutual Insurance Company meets the provisions set forth in Rule and Regulation 19 as well as all applicable requirements of the Arkansas Department of Insurance.

Jeanne Hankerson
2013.01.21 08:34:23 -06'00'

Jeanne H. Hankerson First Vice President – Director of Compliance

January 21, 2013

121 East Park Square
P.O. Box 328 • Owatonna, MN 55060
Phone: (507) 455-5200 • 800-533-0472

FEDERATED MUTUAL INSURANCE COMPANY

READABILITY CERTIFICATION

for the state of

ARKANSAS

GH 03 10 (01-12 ed.)
GH 03 11 (01-12 ed.)

To the best of my knowledge and belief, these forms meet the Flesch minimum reading ease score of the Arkansas readability requirements with a combined score of 50.41.

Jeanne Hankerson
2013.01.21 08:35:54 -06'00'

Jeanne H Hankerson First Vice President

January 21, 2013

☐ Federated Mutual Insurance Company
☐ Federated Life Insurance Company

FEDERATED INSURANCE®

Federated Life Insurance Company
Federated Mutual Insurance Company
Home Office: Owatonna, MN 55060

Employer Application Form, Contribution and Participation Agreement to Federated Health Choice

Section I: General Information

1. **Employer's Legal Name:** _____ Phone No.: _____
   _____ Fax No.: _____
2. **Employer's Address:** _____
   _____ County: _____
   FEIN #: _____
3. **Name and Title of Contact Person:** _____
4. **Name and Title of the Plan Administrator:** _____
5. **Business is:** ☐ Corporation ☐ Partnership ☐ Proprietorship ☐ Other: _____
   Are any affiliated companies or subsidiaries to be included with the employer named above? ☐ Yes ☐ No
   If "yes", explain and give details including names, addresses, number of employees and financial relationships.
   _____
6. **Nature of Employer's Business:** _____ Date Established: _____
7. **Number of Persons Employed:** Part-time _____ Full-time _____ Total _____
   Number of Employees:
   Enrolling _____ In Waiting Period _____ Covered Under Separate Employer's Plan _____
8. Does Employer employ any **temporary, seasonal, commissioned or contract** individuals? ☐ Yes ☐ No
   If "yes", explain: _____
9. **Are there any classes of employee (other than part-time) to be excluded from participation?** ☐ Yes ☐ No
   If "yes", explain (number to be excluded): _____
10. **Are all employees covered by Social Security?** ☐ Yes ☐ No **Workers Compensation?** ☐ Yes ☐ No
    Give the names of those who are not: _____
11. **Is this plan intended to replace any existing group health coverage?** ☐ Yes ☐ No **Dental Coverage?** ☐ Yes ☐ No
12. **Is this plan intended to be in addition to any other group Life and/or Health presently in force?** ☐ Yes ☐ No
13. **Employer Contributions:**
    Please indicate the percent of monthly premium or specific dollar amount the employer pays toward the cost of:
    Employee's Health _____ Life _____ Disability Income _____
    Dependent's Health _____ Dental _____ Other _____

Section II: Benefits Applied For

Health Plan #: _____ **Requested Effective Date:** _____
Deductible: _____ **Coinsurance:** _____ **PPO Network Name:** _____
Waiting Period - 1st of the month following: ☐ 1 month ☐ 2 months ☐ 3 months

Dental: * ☐ None ☐ $500 ☐ $1,000 ☐ $1,500 ☐ $2,000
Disability Income: ☐ None ☐ $100 ☐ $150 ☐ $200 ☐ $300 ☐ $400 ☐ $500
Life Insurance: ** ☐ None Level Amount $_____
Class Based Class I definition _____ Amount $_____
Class II definition _____ Amount $_____
Class III definition _____ Amount $_____

* Limited to employers with 5 or more enrolled for health. New firms need to be replacing dental to qualify for $1,000 benefit.

** Amounts reduce at age 65, 70 and 75. See proposal.

(See Reverse Side)

Section III: Employer's Agreement

The undersigned employer agrees:

1. That the information provided in this enrollment form is complete and true and will be the basis upon which insurance may be approved under the policy.
2. That only persons who are actively working at least 30 hours per week on a regular basis for the undersigned employer are eligible for insurance.
3. That if the employer is paying the entire cost of the plan, 100% of eligible employees and dependents not covered under a separate employer's plan will be enrolled at all times.
4. That if employees contribute to the cost of the plan, a minimum of 85% of all eligible employees and dependents not covered under a separate employer's plan will be enrolled on the plan at all times.
5. That in no event will the employer's purchase of the policy be approved or continued unless a minimum of 2 eligible employees are always insured by the plan. (Does not apply where state law prohibits)
6. That all new full-time employees are eligible for participation in this plan on the first day of the month following completion of the waiting period designated under Section II.
7. That no insurance will become effective without approval by Federated Mutual Insurance Company and Federated Life Insurance Company from its Home Office and no coverage will become effective on any employee or dependent who does not meet the eligibility provisions of the policy.
8. To contribute a percentage or dollar amount equivalent to a minimum of 70% of the employee premium or 35% of total employee and dependent premium.
9. The undersigned employer is the Plan Sponsor and Plan Administrator for the employer's Employee Security Benefits Plan.
10. If approved for insurance under the policies:
    - **A.** The employer is bound by all the provisions of the insurance policies issued by Federated to the employer and as those policies may from time to time be amended.
    - **B.** The employer will remit and initial deposit equal to the first month's premium and pay all subsequent premium by the first of the month as they come due and that failure to remit the required premium may result in termination of coverage.
    - **C.** The employer will make the program of insurance available to all eligible employees and their eligible dependents.
    - **D.** The employer will furnish to Federated or its designated agent any information required in connection with administration of the Plan.

Section IV: Signature

The employer requests that Federated Mutual Insurance Company and Federated Life Insurance Company, hereinafter called Federated, approve it for coverage under the insurance policies.

On behalf of the Employer, I hereby certify that I have read this application form and that the information provided is true and accurate.

Employer's Legal Name: _____

_____

Authorized Signature: _____ Title: _____

Print Name: _____ Date: _____

Witness: _____

_____ Territory Code: _____

Agent's Name (print, type of stamp)

NOTICE: Any person who, with intent to injure, defraud or deceive any insurance company, submits a statement of claim or application containing false, incomplete or misleading information, may be subject to criminal and/or civil penalties. Coverage may be rescinded for fraud or intentional misrepresentation of a material fact in this application.

FEDERATED INSURANCE®

Internal use only: Acct # _____

Employee Enrollment and Record Form

☐ Federated Life Insurance Company
☐ Federated Mutual Insurance Company
Attn: Group Health Administration
1929 S. Cedar, Owatonna, MN 55060
Toll Free: (800) 377-9154 Fax: (507) 446-4697

Please complete this form carefully. The effective date may be delayed if vital information is missing.

Please print in black ink

SECTION 1: EMPLOYEE INFORMATION

Employee's Last Name _____ First Name _____ Middle Initial ____ ☐ Single ☐ Married Number of dependent children _____

Social Security # _____ **Gender** ☐ M ☐ F **Date of Birth** _____ **Height** _____ ft. _____ in **Weight** _____ lbs

Home Street Address City/State/Zip

Employer's Name City/State/Zip

Job Title	Are you an owner or officer? ☐ Yes ☐ No	**Date employed full-time** (mm/dd/yy)	**Hours worked per week**

Are you (the employee) actively working on a **full-time basis** and receiving a W2 from this employer? ☐ Yes ☐ No

If no longer receiving a wage **from this employer**, what was your last date of employment? (mm/dd/yy) _____ ☐ N/A

How may we contact you if we need more information? Cell Phone ( ) Work phone ( ) Home phone ( ) Best time to call? _____ am/pm (circle one)

SECTION 2: DEPENDENT INFORMATION – *List all dependents applying for coverage*

(Eligible dependents include legal spouse, children under age 26 or disabled children of any age.)

Spouse's Last Name _____ **First Name** _____ **Middle Initial** _____ **Date of Marriage** _____

Social Security # _____ Gender ☐ M ☐ F Date of Birth _____ Height _____ ft. _____ in Weight _____ lbs

Dependent Child(ren) Names (First, Middle Initial, Last)	Social Security Number	Date of Birth (mm/dd/yy)	Gender	Relationship to Employee	Resides in your home?
			☐ Male ☐ Female	☐ Natural/adopted child ☐ Stepchild ☐ Other	☐ Yes ☐ No
			☐ Male ☐ Female	☐ Natural/adopted child ☐ Stepchild ☐ Other	☐ Yes ☐ No
			☐ Male ☐ Female	☐ Natural/adopted child ☐ Stepchild ☐ Other	☐ Yes ☐ No
			☐ Male ☐ Female	☐ Natural/adopted child ☐ Stepchild ☐ Other	☐ Yes ☐ No

SECTION 3: BENEFIT SELECTION

(The availability of benefits are based on those offered by your employer)

Select Employee Benefits (Choose One):

☐ All coverages offered by employer
☐ Life, Dental, & Short Term Disability Only (if offered)
☐ Currently enrolled in COBRA or State Continuation
☐ No coverage **(complete Section 4)**

AND

Select Dependent Benefits (Choose One):

☐ Spouse and dependent children
☐ Spouse only
☐ Dependent children only
☐ No coverage **(complete Section 4)**

SECTION 4: DECLINING COVERAGE

(Complete if declining coverage for you, your spouse, or your dependent children)

I am declining health coverage for (check all that apply) ☐ Myself ☐ My Spouse ☐ My Children

because I/we are (choose one) ☐ Covered Elsewhere. Name of insurer _____

☐ Other Explain _____

IMPORTANT: DESCRIPTION OF SPECIAL ENROLLMENT RIGHTS

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance coverage, you may in the future be able to enroll yourself or your dependents in this plan, provided that you are otherwise eligible and request enrollment within 30 days after your coverage ends. In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents, provided that you request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption. If no additional premium is required for a new dependent, the 30-day enrollment requirement does not apply.

SECTION 5: LIFE INSURANCE BENEFICIARY

(Complete only if applying for life insurance)

Primary Beneficiary:		**Contingent Beneficiary(ies):**	
Legal Name	Relationship	Legal Name	Relationship
Date of Birth	Address	Legal Name	Relationship

Continue on Reverse Side ➡

SECTION 6: HEALTH INFORMATION
(Answer each of the following for **you, your spouse, and each dependent** listed in section 2)

During the *past 5 years*, has any person had, been told they have, or received treatment or follow-up care for:		**Circle all that apply and provide details in Sections 7 and 8**
1. ☐ Yes ☐ No	**Heart/Circulatory**	High Blood Pressure, High Cholesterol, Stroke, Heart Attack, Angioplasty, Aneurysm, Vascular Disease, By-Pass Surgery, Irregular Heart Beat, Heart Valve Problems, Anemia, Blood Disorder, Other
2. ☐ Yes ☐ No	**Lung/Respiratory**	Allergies, Asthma, Cystic Fibrosis, Emphysema, Sleep Apnea, COPD, Other
3. ☐ Yes ☐ No	**Intestinal/Endocrine/ Digestive/Liver**	Diabetes (Type I or II), Hepatitis, Colitis, Ulcerative Colitis, Pancreatitis, Cirrhosis, Diverticulitis Hiatal Hernia, Crohn's Disease, Thyroid Disorder, Other
4. ☐ Yes ☐ No	**Urinary/Kidney**	Kidney Stones, Dialysis, Polycystic Kidneys, Infection, Renal Failure, Enlarged Prostate, Other
5. ☐ Yes ☐ No	**Brain/Nervous**	Multiple Sclerosis, Epilepsy, Seizures, Cerebral Palsy, Paralysis, Brain Injury, Other
6. ☐ Yes ☐ No	**Skeletal/Muscle**	Back/Neck Pain, Hernia, Fibromyalgia, Lupus, Muscular Dystrophy, Osteoarthritis, Rheumatoid Arthritis, Joint Replacement, Artificial Limb, Other
7. ☐ Yes ☐ No	**Mental Health**	Anxiety, Depression, Alcohol/Drug Abuse, ADD/ADHD, Bipolar, Anorexia/Bulimia, Other
8. ☐ Yes ☐ No	**Cancer/Tumor/Growth**	Cancer or Tumor (provide location below), Benign Polyp, Hodgkins, Leukemia, Other
9. ☐ Yes ☐ No	**Transplant**	If transplant complete: Organ _____ Date of Transplant _____ If transplant pending: Organ _____ Date Expected _____
10. ☐ Yes ☐ No	Has any person been diagnosed or treated by a physician for AIDS, ARC, or AIDS related condition?	
11a. ☐ Yes ☐ No	Are you or an eligible dependent (even if not enrolling for coverage) an expectant parent? If yes, due date is : _____	
11b. ☐ Yes ☐ No	Are there previous or current complications, previous or current multiple births, or a C-section expected (Circle all that apply & explain in Sections 7 and 8).	
12. ☐ Yes ☐ No	Is any person to be insured currently disabled, hospitalized, on medical leave, or handicapped? (circle all that apply)	
13. ☐ Yes ☐ No	Other than #1-12 above has any person received medical advice or treatment for any condition during the past 5 years? If yes, explain in Sections 7 and 8.	
14. ☐ Yes ☐ No	Is there any medical condition that will require treatment or surgery in the next 24 months on any person to be insured? If yes, explain in Sections 7 and 8.	
15. ☐ Yes ☐ No	Tobacco Use: By whom? Type? Start Date? Stop Date?	
16. ☐ Yes ☐ No	Are any of the above conditions or medications currently covered under Medicare, worker's compensation, auto, or liability coverage? (If yes, circle coverage that applies)	List the condition(s):

SECTION 7: Complete for ALL medical conditions circled and/or checked above
(Please use an additional page, if needed)

Question #	Person's Name	Diagnosis (name of injury or illness)	Treatment Received	Date of Onset	Date of full recovery or "Not yet recovered"

SECTION 8: MEDICATIONS: Complete for each person applying for coverage
(List ALL medications taken, use an additional page if needed)

Question #	Person's Name	Medication	Reason Prescribed	# per day	Dosage (mg/gm)	Date first prescribed	Still Prescribed?
							☐ Yes ☐ No
							☐ Yes ☐ No
							☐ Yes ☐ No
							☐ Yes ☐ No
							☐ Yes ☐ No

SECTION 9: EMPLOYEE AUTHORIZATION AND REPRESENTATION
(Read this section, sign, and date this form even if not enrolling for coverage)

A person who submits an application or files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime.

Agreement: I represent that I have read or have had read to me the completed form and the above answers are, to the best of my knowledge and belief, complete and true and, together with any supplements thereto, shall be the basis for any certificate of insurance issued and that the insurance company may withdraw the coverage for which I am applying and may consider such coverage as having never been in effect, if any information is substantially incomplete or incorrect.

I hereby enroll (or decline to be enrolled) in group insurance plan(s) through Federated Insurance. With my enrollment, I authorize my employer to deduct from my earnings an amount sufficient for my contribution, if any, toward the group insurance premiums.

Employee's Signature	Date Signed	Spouse's Signature (if applying for coverage)	Date Signed

This form MUST be dated and signed

PPACA Uniform Compliance Summary

Please select the appropriate check box below to indicate which product is amended by this filing.

☐ **INDIVIDUAL HEALTH BENEFIT PLANS** ***(Complete SECTION A only)***

☑ **SMALL / LARGE GROUP HEALTH BENEFIT PLANS** ***(Complete SECTION B only)***

This form filing compliance summary is to be submitted with your [endorsement][contract] to comply with the immediate market reform requirements of the Patient Protection and Affordable Care Act (PPACA). These PPACA requirements apply only to policies for health insurance coverage referred to as "major medical" in the statute, which is comprehensive health coverage that includes PPO and HMO coverage. This form includes the requirements for grandfathered (coverage in effect prior to March 23, 2010) and non-grandfathered plans, and relevant statutes. Refer to the relevant statute to ensure compliance. Complete each item to confirm that diligent consideration has been given to each. (*If submitting your filings electronically, bookmark the provision(s) in the form(s) that satisfy the requirement and identify the page/paragraph on this form.*)

***For all filings, include the Type of Insurance (TOI) in the first column.**

☐ Check box if this is a paper filing.

COMPANY INFORMATION

Company Name	NAIC Number	SERFF Tracking Number(s) *if applicable	Form Number(s) of Policy being endorsed	Rate Impact
Federated Mutual Insurance Company	13935	FEMC-127384610 State Tracking No: 49633	GH 03 10 (01-12 ed.)	☐ Yes ☑ No

PPACA Uniform Compliance Summary

Reset Form

SECTION A – Individual Health Benefit Plans				
TOI	**Category**	**Statute Section**	**Grandfathered**	**Non-Grandfathered**
	Eliminate Pre-existing Condition Exclusions for Enrollees Under Age 19	*[Sections 2704 and 1255 of the PHSA/Section 1201 of the PPACA]*	N/A	☐ **Yes** ☐ No If **no**, please explain.
	Explanation:			
	Page Number:			
	Eliminate Annual Dollar Limits on Essential Benefits Except allows for "restricted" annual dollar limits for essential benefits for plan years prior to January 1, 2014.	*[Section 2711 of the PHSA/Section 1001 of the PPACA]*	N/A	☐ **Yes** ☐ No If **no**, please explain.
	Explanation:			
	Page Number:			
	Eliminate Lifetime Dollar Limits on Essential Benefits	*[Section 2711 of the PHSA/Section 1001 of the PPACA]*	☐ **Yes** ☐ No If **no**, please explain.	☐ **Yes** ☐ No If **no**, please explain.
	Explanation:			
	Page Number:			
	Prohibit Rescissions – Except for fraud or intentional misrepresentation of material fact.	*[Section 2712 of the PHSA/Section 1001 of PPACA]*	☐ **Yes** ☐ No If **no**, please explain.	☐ **Yes** ☐ No If **no**, please explain
	Explanation:			
	Page Number:			

PPACA Uniform Compliance Summary

SECTION A – Individual Health Benefit Plans				
TOI	**Category**	**Statute Section**	**Grandfathered**	**Non-Grandfathered**
	Preventive Services – Requires coverage and prohibits the imposition of cost-sharing for specified preventative services.	*[Section 2713 of the PHSA/Section 1001 of the PPACA]*	N/A	☐ **Yes** ☐ No If **no**, please explain.
	Explanation:			
	Page Number:			
	Extends Dependent Coverage for Children Until age 26 – If a policy offers dependent coverage, it must include dependent coverage until age 26.	*[Section 2714 of the PHSA/Section 1001 of the PPACA]*	☐ **Yes** ☐ No If **no**, please explain.	☐ **Yes** ☐ No If **no**, please explain.
	Explanation:			
	Page Number:			
	Appeals Process – Requires establishment of an internal claims appeal process and external review process.	*[Section 2719 of the PHSA/Section 1001 of the PPACA]*	N/A	☐ **Yes** ☐ No If **no**, please explain.
	Explanation:			
	Page Number:			
	Emergency Services – Requires plans that cover emergency services to provide such coverage without the need for prior authorization, regardless of the participating status of the provider, and at the in-network cost-sharing level.	*[Section 2719A of the PHSA/Section 10101 of the PPACA]*	N/A	☐ **Yes** ☐ No If **no,** please explain.
	Explanation:			
	Page Number:			

PPACA Uniform Compliance Summary

SECTION A – Individual Health Benefit Plans				
TOI	**Category**	**Statute Section**	**Grandfathered**	**Non-Grandfathered**
	Access to Pediatricians – Mandates that if designation of a PCP for a child is required, the person be permitted to designate a physician who specialized in pediatrics as the child's PCP if the provider is in-network.	*[Section 2719A of the PHSA/Section 10101 of the PPACA]*	N/A	☐ **Yes** ☐ No If **no**, please explain.
	Explanation:			
	Page Number:			
	Access to OB/GYNs – Prohibits authorization or referral requirements for obstetrical or gynecological care provided by in-network providers who specialize in obstetrics or gynecology.	*[Section 2719A of the PHSA/Section 10101 of the PPACA]*	N/A	☐ **Yes** ☐ No If **no**, please explain.
	Explanation:			
	Page Number:			

PPACA Uniform Compliance Summary

Reset Form

SECTION B – Group Health Benefit Plans (Small and Large)				
TOI	**Category**	**Statute Section**	**Grandfathered**	**Non-Grandfathered**
	Eliminate Pre-existing Condition Exclusions for Enrollees Under Age 19	*[Sections 2704 of the PHSA/Section 1201 of the PPACA]*	☑ **Yes** ☐ No If **no**, please explain.	☑ **Yes** ☐ No If **no**, please explain.
	Explanation: This filing eliminates the pre-existing condition limitation for everyone covered by the policy.			
	Page Number:			
	Eliminate Annual Dollar Limits on Essential Benefits – Except allows for "restricted" annual dollar limits for essential benefits for plan years prior to January 1, 2014.	*[Section 2711 of the PHSA/Section 1001 of the PPACA]*	☑ **Yes** ☐ No If **no**, please explain.	☑ **Yes** ☐ No If **no**, please explain.
	Explanation:			
	Page Number: Schedule of Benefits, Page 4			
	Eliminate Lifetime Dollar Limits on Essential Benefits	*[Section 2711 of the PHSA/Section 1001 of the PPACA]*	☑ **Yes** ☐ No If **no**, please explain.	☑ **Yes** ☐ No If **no,** please explain.
	Explanation:			
	Page Number: Schedule of Benefits, Page 4			
	Prohibit Rescissions – Except for fraud or intentional misrepresentation of material fact.	*[Section 2712 of the PHSA/Section 1001 of PPACA]*	☑ **Yes** ☐ No If **no**, please explain.	☑ **Yes** ☐ No If **no**, please explain.
	Explanation:			
	Page Number: Section 1, Page 2, No. 7 - Right to Contest			

PPACA Uniform Compliance Summary

SECTION B – Group Health Benefit Plans (Small and Large)				
TOI	**Category**	**Statute Section**	**Grandfathered**	**Non-Grandfathered**
	Preventive Services – Requires coverage and prohibits the imposition of cost-sharing for specified preventative services	*[Section 2713 of the PHSA/Section 1001 of the PPACA]*	N/A	☑ **Yes** ☐ No If **no**, please explain.
	Explanation:			
	Page Number: Section 6, Page 7, No. 25 and Schedule of Benefits, Page 4			
	Extends Dependent Coverage for Children Until age 26 – If a policy offers dependent coverage, it must include dependent coverage until age 26. ◊	*[Section 2714 of the PHSA/Section 1001 of the PPACA]*	☑ **Yes**◊ ☐ No If **no**, please explain.	☑ **Yes** ☐ No If **no**, please explain.
	Explanation:			
	Page Number: Section 8, Page 5, No. 29			
	Appeals Process – Requires establishment of an internal claims appeal process and external review process.	*[Section 2719 of the PHSA/Section 1001 of the PPACA]*	N/A	☑ **Yes** ☐ No If **no**, please explain.
	Explanation:			
	Page Number: Section 9			

◊ For plan years beginning before January 1, 2014, grandfathered group plans are not required to extend coverage to a child until the age of 26 if such child is eligible to enroll in another employee-sponsored plan

PPACA Uniform Compliance Summary

SECTION B – Group Health Benefit Plans (Small and Large)				
TOI	**Category**	**Statute Section**	**Grandfathered**	**Non-Grandfathered**
	Emergency Services – Requires plans that cover emergency services to provide such coverage without the need for prior authorization, regardless of the participating status of the provider, and at the in-network cost-sharing level.	*[Section 2719A of the PHSA/Section 10101 of the PPACA]*	N/A	☑ **Yes** ☐ No If **no**, please explain.
	Explanation:			
	Page Number: Section 1, Page 3 & 4 No. 16.a. & Schedule of Benefits, Page 4			
	Access to Pediatricians – Mandates that if designation of a PCP for a child is required, the person be permitted to designate a physician who specialized in pediatrics as the child's PCP if the provider is in-network.	*[Section 2719A of the PHSA/Section 10101 of the PPACA]*	N/A	☐ **Yes** ☑ No If **no**, please explain.
	Explanation: Policy has no PCP requirement.			
	Page Number:			
	Access to OB/GYNs – Prohibits authorization or referral requirements for obstetrical or gynecological care provided by in-network providers who specialize in obstetrics or gynecology.	*[Section 2719A of the PHSA/Section 10101 of the PPACA]*	N/A	☐ **Yes** ☑ No If **no**, please explain.
	Explanation: No referral requirement in policy.			
	Page Number:			

SECTION II - ENROLLMENT & EFFECTIVE DATE

Words and phrases appearing in **bold type** have special meaning as set forth in Section VIII - Definitions.

1. **EMPLOYER** ENROLLMENT AND EFFECTIVE DATE

   a. An **employer** shall apply to become a ~~covered **employer** or~~ **policyholder**. The **employer** will become a ~~**covered employer** or~~ **policyholder** on the first day of the **month** coinciding with or following the date such **employer** applies subject to:

      ~~a.~~i. approval by **us**; and

      ~~b.~~ii. meeting the participation requirements shown below; and

      ~~c.~~iii. meeting the contribution requirements shown below.

   b. Once an **employer** becomes a **policyholder** they can make changes to the policy chosen either:

      i. prior to the anniversary of their original effective date to be effective on the anniversary of their original effective date; or

      ii. prior to 12:01 am Central Standard Time on December 15 any **calendar year** to be effective on the first day of January.

2. PARTICIPATION REQUIREMENTS

   a. When the **employer** pays the entire premium:

      If the **employer** is paying the entire premium for each **covered employee**, 100% of the eligible **employees** not covered under a separate unrelated employer's plan must be enrolled for coverage at all times.

      If the **employer** is paying the entire premium for each covered **dependent**, 100% of the eligible **dependents** not covered under a separate unrelated employer's plan must be enrolled for coverage at all times.

   b. When **covered employees** contribute to the premium payment:

      If **covered employees** contribute to the premium payment for their own coverage, a minimum of 85% of all eligible **employees** not covered under a separate unrelated employer's plan must be enrolled at all times.

      If **covered employees** contribute to the premium payment for their **dependents**' coverage, a minimum of 85% of all eligible **dependents** not covered under a separate unrelated employer's plan must be enrolled at all times.

      In addition, a minimum of two (2) eligible **employees** must always be insured under each **employer's** plan in order for coverage to be issued or continued.

3. CONTRIBUTION REQUIREMENTS

   When an **employer** does not pay the full premium for **covered employees** and **dependents**, the **employer** must:

   a. pay a minimum of 70% of the premium for **covered employees**; or

   b. pay a minimum of 35% of the total premium for **covered employees** and **dependents**.

4. **EMPLOYEE** ELIGIBILITY

   a. An **employee** is eligible to enroll for coverage under the **policy** if he is **actively at work** or absent from work due to a **health status related factor** and:

      i. has completed the **waiting period** shown in the **employer's** application for coverage; or

      ii. was covered under the **employer's** prior plan on the day before the effective date of the **employer's** coverage with **us**.

   b. An **employee** is only eligible for **dependent** coverage if he elects **employee** coverage.

   c. Once enrolled, an **employee** is eligible for coverage under the **policy** only if he is **actively at work**.

5. **DEPENDENT** ELIGIBILITY

a. **Dependents** are eligible to enroll for coverage under the **policy** if:

i. they meet the definition of a **dependent** in Section VIII - Definitions; and

ii. the **employee** is covered under the **policy**; and

iii. the additional premium for **dependent** coverage is paid.

b. Once enrolled, a **dependent** is eligible for coverage under the **policy** only if he meets the definition of a **dependent** in Section VIII - Definitions.

6. OPEN ENROLLMENT PERIOD

The "open enrollment period" will be from 12:01 am Central Standard Time on October 1 through 12:01 am Central Standard Time on December 15 each calendar year. Coverage for an employee or dependent that enrolls during the "open enrollment period" will be effective on the first day of January following their enrollment.

~~6.~~7. **EMPLOYEE** EFFECTIVE DATE

Each eligible **employee** may elect coverage by completing and signing an application. The effective date of his coverage depends upon the date on which the **employee** elects the coverage.

a. If elected on or before the date he becomes eligible, his coverage will be effective on the first day of the **month** after he becomes eligible.

b. If elected within 31 days after he becomes eligible, his coverage will be effective on the first day of the **month** after election.

c. If not elected ~~more than~~within 31 days after he becomes eligible, an **employee** can only enroll for coverage during the "open enrollment period" established by **us** or according to the special enrollment provisions in item 11 below. If an **employee** enrolls during an "open enrollment period" his coverage will be effective on the first day of January following his enrollment.~~his coverage will be effective on the first day of the **month** after **we** receive his application for coverage.~~

~~d.If his coverage ceased because he cancelled his payroll deduction, and he again elects to be insured, his coverage will be effective on the first day of the **month** after **we** receive his application for coverage.~~

~~7.~~8. **DEPENDENT** EFFECTIVE DATE (other than newborn or adopted children)

Each **covered employee** may elect **dependent** coverage by completing and signing an application. The effective date of coverage for each **dependent**, except newborn or adopted children, depends upon the date on which the **employee** elects coverage for that **dependent**. If a **dependent** is no longer covered because his eligibility ended, he must re-enroll for coverage if he becomes eligible again. Coverage is not automatically reinstated for **dependents** that were previously covered.

Coverage for a newborn or adopted child is effective as outlined in subparts ~~8.~~9 & ~~9.~~10 below.

a. If elected on or before the date the **employee** becomes eligible, the coverage for each **dependent** will be effective on the first day of the **month** after the **employee** becomes eligible.

b. If elected within 31 days after the **employee** becomes eligible, the coverage for each **dependent** will be effective on the first day of the **month** after election.

c. If not elected ~~more than~~within 31 days after the **employee** becomes eligible, ~~the coverage for~~ each **dependent** can only enroll for coverage during the "open enrollment period" established by **us** or according to the special enrollment provisions in item 11 below. If a **dependent** enrolls during an "open enrollment period" his coverage will be effective on the first day of January following his enrollment.~~will be effective on the first day of the **month** after **we** receive his application for coverage.~~

~~d.If the **employee's dependent** coverage terminated because he cancelled his payroll deduction and he again elects to be insured, the coverage for each **dependent** will be effective on the first day of the **month** after **we** receive his application for coverage.~~

~~e.~~d. If the **employee** acquires an additional **dependent**~~:~~ the effective date of coverage will be according to the special enrollment provisions in item 11 below.

~~i.If elected on or before he becomes a **dependent**, coverage will be effective on the date he qualifies as a **dependent**.~~

ii.If elected after the date he becomes a **dependent**, coverage will be effective on the first day of the month after **we** receive his application for coverage.

8.9. NEWBORN'S EFFECTIVE DATE

The effective date of coverage for a newborn **dependent** child who is born while an **employee** is a **covered employee** will be as follows:

a. Coverage will be in effect from the moment of birth if within 90 days of the birth of a child who would qualify as a **dependent** of the **covered employee**:

   i. notifies **us** of the birth of a child; and

   ii. **we** receive payment of any required premium for coverage of the child as a **dependent**

b. If the **covered employee** does not provide notice and pay any required premium within 31 90 days of the birth of a child who would qualify as a **dependent**, coverage for that child can only be added during the "open enrollment period" as set forth above or according to the special enrollment provisions in item 11 below. If a newborn **dependent** enrolls during an "open enrollment period" his coverage will be effective on the first day of January following his enrollment.will be effective on the first day of the **month** after **we** receive an application for coverage for that child.

9.10. ADOPTED CHILD EFFECTIVE DATE

The effective date for a **dependent** child who is adopted by an **employee** while he is a **covered employee** will be as follows:

a. Coverage will be in effect from the date of the "placement for adoption" if within 60 days of the "placement for adoption" of a child who would qualify as a **dependent** the **covered employee**:

   i. notifies **us** of the "placement for adoption" of the child; and

   ii. **we** receive payment of any required premium for coverage of the child as a **dependent.**

b. If the **covered employee** does not provide notice and pay any required premium within 60 days of the "placement for adoption" of a child who would qualify as a **dependent**, coverage for that child can only be added during the "open enrollment period" as set forth above or according to the special enrollment provisions in item 11 below. If an adopted **dependent** enrolls during an "open enrollment period" his coverage will be effective on the first day of January following his enrollment.will be effective on the first day of the **month** after **we** receive an application for coverage for that child.

   The term "Placement for Adoption" means the earlier of:

   i. the date of placement of the child with the **covered employee** for purposes of adoption;

   ii. the date of entry of an order granting the **covered employee** custody of the child for purposes of adoption; or

   iii. the effective date of the adoption by the **covered employee**.

   The child's placement with the **covered employee** terminates if prior to legal adoption the child is removed from the placement.

10.11. SPECIAL ENROLLMENT PROVISIONS

a. For Individuals Losing Other Coverage

   An **employee** and any eligible **dependents** who are otherwise eligible under the **policy**; and failed to enroll when first eligible may enroll for coverage outside the "open enrollment period", but only if each of the following conditions are met:

   i. the **employee** and/or any eligible **dependents** were covered under a group health plan or had other health coverage (includes benefits consisting of medical care under any hospital or medical services policy or certificate, or HMO policy) at the time coverage under the **policy** was first offered; and

   ii. the **employee** stated in writing that coverage under such group health plan or health insurance coverage was the reason for declining enrollment; but only if **we** required such a statement and provided the **employee** with notice of such requirement (and the consequences of such requirement) at such time; and

   iii. if such coverage:

(1) was under a **COBRA** continuation provision and the coverage under such provision was exhausted; or

(2) was not under a **COBRA** continuation provision and the coverage was terminated as a result of either:

(a) legal separation; divorce; death; termination of employment; or reduction in the number of hours of employment; or

(b) the current or former employer contributions toward such coverage terminating; and

iv. the **employee** requests enrollment under the **policy** for the **employee** and/or any eligible **dependents** not later than 30 days after the date such other coverage ended. The coverage will become effective on the first day of the **month** following **our** receipt of the enrollment request; or on an earlier date, as agreed to by **us**.

b. For Individuals Otherwise Eligible

In addition to the eligibility provisions contained in the **policy**, the following also applies:

i. If the **employee** is covered under the **policy** (or has met any **waiting period** and is eligible to enroll under the **policy**, but did not enroll during a previous enrollment period); and a person becomes an eligible **dependent** through marriage, birth, adoption or placement for adoption; **we** will provide:

(1) a special enrollment period described below during which such **dependent** may be enrolled under the **policy**;

(2) in the case of the birth or adoption of a child, a special enrollment period for the **employee's spouse** to enroll as a **dependent** if otherwise eligible for coverage.

The **employee** must be eligible for coverage and enrolled under the **policy** for coverage to be effective for the **employee's dependent**. If the **employee** is not enrolled, the **employee** may enroll at the same time as the **dependent** during this special enrollment period.

ii. The special enrollment period will be a period of 30 days, and begins on the later of:

(1) the date **dependent** coverage is made available under the **policy**; or

(2) the date of the marriage, birth, adoption or placement for adoption.

iii. If the **employee** requests enrollment under the **policy** for the **employee** and/or any eligible **dependents** during the 30 days of such special enrollment period, the coverage will be effective:

(1) in the case of marriage, on the first day of the **month** following **our** receipt of the enrollment request; or on an earlier date as agreed to by **us**;

(2) in the case of a **dependent's** birth, on the date of such birth; or

(3) in the case of a **dependent's** adoption or placement for adoption, the date of such adoption or placement for adoption.

~~11.**PRE-EXISITING CONDITION** PROVISION~~

~~a.The **pre-existing condition** provision will apply if a **covered person**:~~

~~i.becomes insured under the **policy** and was not covered under **creditable coverage**; or~~

~~ii.becomes insured under the **policy** and was covered under **creditable coverage** for an aggregate period of fewer than 12 **months** (18 **months** for a **late enrollee**).~~

~~If a **covered person** has **creditable coverage** for an aggregate period of fewer than 12 **months**, (18 **months** for a **late enrollee**), **we** will reduce the time the **pre-existing condition** provision applies by the amount of time he had **creditable coverage**.~~

~~**Creditable coverage** will not be credited if there was a period of 63 days or more during which the **covered person** was not covered under **creditable coverage** between the end of the prior coverage and his **enrollment date**. However, any **waiting period** will not count as a break in the period of **creditable coverage**.~~

~~b.If the **pre-existing condition** provision applies, **we** will not pay **benefits** for **a pre-existing condition** prior to the day after a 12 consecutive **month** period has passed from the **covered person's enrollment date**~~

(18 consecutive **months** for a **late enrollee**). **We** will then pay only for **covered services** for a **pre-existing condition** incurred after the 12 consecutive **month** period (18 **months** for a **late enrollee**).

c.Exceptions

The **pre-existing condition** provision does not apply to:

i.pregnancy, including complications;

ii.genetic information in the absence of a diagnosis of a condition related to such information; or

iii.a **covered person** under age 19.